V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 7 1943

Registration District No. 1949

Primary Registration District No. 1002

Registrar's No. 2124

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Kansas City T.B. Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 m. 2 d.
(Specify whether In this community years, months or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 3941 Forest 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ester Nellie Mason

3. (b) If veteran, name war —no

3. (c) Social Security No. none

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Paul Mann

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Jan (Month) 15 (Day) 1905 (Year)

8. AGE: Years 38 | Months 4 | Days 21 | If less than one day hr. min. 2

9. Birthplace Southport (City, town, or county) Indiana (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name James Oakes
13. Birthplace Kent (City, town, or county) Ind. (State or foreign country)

MOTHER
14. Maiden name Nellie Boston
15. Birthplace Kent (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Kansas City T.B. Hosp.
(b) Address K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-43 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Lawn Cemetery

18. (a) Signature of funeral director Freeman Mortuary
(b) Address Kansas City, Mo.

19. (a) 5-7-43 (Date received local registrar) (b) W. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
year 1943 hour 2 00 minute A.M.

21. I hereby certify that I attended the deceased from 8-14-43, 19..., to 5-6, 1943
that I last saw her alive on 5-6, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis Peritonitis Chronic	1½ yr.
Due to: Pulmonary Tuberculosis	1 yr.
Due to: 13 B 1	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Matthew J. Moon (M. D. signature)
Address K.C.T.B. Hosp. Date signed 5/6/43

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed. Clarence N. Coles

Licensed Embalmer No. 3473

P. O. Address 56 Exeter

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.